Justifying medication decisions in mental health care: psychiatrists' accounts for treatment recommendations

Article begins on next page

JUSTIFYING MEDICATION DECISIONS IN MENTAL HEALTH CARE:

PSYCHIATRISTS' ACCOUNTS FOR TREATMENT RECOMMENDATIONS

Beth Angell (angell@ssw.rutgers.edu)

School of Social Work and the Institute for Health, Health Care Policy, and Aging Research

Rutgers, the State University of New Jersey

Galina B. Bolden (gbolden@rci.rutgers.edu)

School of Communication and Information

Rutgers, the State University of New Jersey

To appear in *Social Science & Medicine*

Abstract

Psychiatric practitioners are currently encouraged to adopt a patient centered approach that emphasizes the sharing of decisions with their clients, yet recent research suggests that fully collaborative decision making is rarely actualized in practice. This paper uses the methodology of Conversation Analysis to examine how psychiatrists justify their psychiatric treatment recommendations to clients. The analysis is based on audio-recordings of interactions between clients with severe mental illnesses (such as, schizophrenia, bipolar disorders, etc.) in a long-term, outpatient intensive community treatment program and their psychiatrist. Our focus is on how practitioners design their *accounts* (or rationales) for recommending for or against changes in medication type and dosage and the interactional deployment of these accounts. We find that psychiatrists use two different types of accounts: they tailor their recommendations to the clients' concerns and needs (*client-attentive accounts*) and ground their recommendations in their professional expertise (*authority-based accounts*). Even though psychiatrists have the institutional mandate to prescribe medications, we show how the use of accounts displays psychiatrists' orientation to building consensus with clients in achieving medical decisions by balancing medical authority with the sensitivity to the treatment relationship.

Key words: United States, psychiatry, mental health, Assertive Community Treatment, accounts, Conversation Analysis, medical recommendations, shared decision-making

Justifying medication decisions in mental health care: Psychiatrists' accounts for treatment

recommendations

Within psychiatry, medications are considered a cornerstone of treatment; yet the process

by which treatment decisions are made is poorly understood. On the basis of field recordings of

actual psychiatric visits, this study analyzes how psychiatrists justify their psychiatric treatment

recommendations to clients. We find that psychiatrists use two different types of *accounts:* they

tailor their recommendations to the clients' concerns and needs (*client-attentive accounts*) and

ground their recommendations in their professional expertise (*authority-based accounts*). Even

though psychiatrists have the institutional mandate to prescribe medications, we show how the

use of accounts displays psychiatrists' orientation to building consensus with clients in achieving

medical decisions by balancing medical authority with the sensitivity to the treatment

relationship.

Patient-centered care in psychiatry

A growing body of literature points to the importance of patient-centered care in the field

of community mental health, mirroring trends in many areas of medicine (Institute of Medicine

Committee on Quality of Health in America, 2006; President's New Freedom Commission on

Mental Health, 2003). Patient-centeredness, often described as a philosophy rather than a

formalized model of care, emphasizes two key ideas. First, it highlights the importance of

treatment relationships in which providers understand and respond to their clients' needs, values,

and preferences, and from these understandings, come to a mutual understanding of the problems

and issues under consideration (Epstein et al., 2005). This component of patient-centered care

parallels the concept of a "therapeutic alliance" or working relationship, which has long been

considered a cornerstone of successful treatment in both psychiatry and psychotherapy (e.g., Norcross, 2002; Priebe et al., 2011).

A second core component of the patient-centered care philosophy encourages the practitioner to invite the patient to take an active role in making medical decisions through a collaborative partnership with the provider (Epstein et al., 2005). Inclusion of the patient or client is often referred to as shared decision making (SDM), and this component in particular has been promoted in the field of psychiatry as a critically important direction for operationalizing foundational values of choice, self-determination, and empowerment (Drake & Deegan, 2009). SDM is conceptualized as a collaborative process wherein both clinician and patient share information about risks, benefits, preferences, and values related to a health care decision. From this bidirectional exchange, patient and clinician should each be prepared to engage in deliberation and shared responsibility regarding the final decision, which they mutually agree to implement (Barry & Edgman-Levitan, 2012; Charles et al., 1999).

Although SDM is promoted widely as a philosophy and style of practice, recent research suggests that it is only partially actualized in mental health treatment (Matthias et al., 2012; Salyers et al., 2012; Woltmann & Whitley, 2010). Observational studies of psychiatric practice show that even when clients and providers agree nominally upon treatment decisions, the process that leads to this agreement tends to omit important components of SDM, such as discussion of alternatives and negotiation about the client's role in making the decision (Matthias et al., 2012; Salyers et al., 2012). Research that inquires about client preferences for shared decision making suggests that many desire a more participatory role and perceive that acquiescence to their providers is both expected and naturalized within the psychiatric setting (Woltmann & Whitley, 2010).

The discrepancy between the prevailing ideology of SDM and the practice of medication management as described in the psychiatric literature thus requires greater exploration. Studies which examine the perspectives of providers report that clinicians express concerns about risk management, their colleagues' disapproval, and pessimism regarding their clients' capacities for making sound decisions (Mahone et al., 2011; Seale et al., 2006). These perspectives accord with sizeable literatures illustrating that those patients who are least likely to adhere to treatment and who exhibit disagreement with their providers about clinical needs are those with lower "insight," or awareness of their illness (Carter, 2003; Olfson et al., 2006). With such clients, providers often feel obliged to adopt a paternalistic approach by using methods of persuasion and even coercion (Brodwin, 2013). Clients may also, at times, accept providers' suggestions out of respect to their expertise, deference to their institutional authority, and desire to align with and maintain relationships with providers, who often represent a conduit to needed resources (Angell et al., 2014).

In recognition that patient-centered practice has proven challenging across a variety of fields of medicine, Pilnick and Dingwall (2011) suggest that this is because provider-client asymmetry is embedded in the institution of medicine and, in fact, functional to its effective operation (Pilnick & Dingwall, 2011). From this point of view, the accountability with which physicians are vested places major constraints upon collaborative decision-making. Indeed, such approaches may be in fact undesirable or poorly received by patients because they undermine the social order that is taken for granted by all parties in a medical encounter. In this sense, shared decision making approaches could be resisted as much by clients, who seek medical expertise to deal with a problem, as by providers, who are socialized to exercise authority. In psychiatry this argument is, however, complicated by the fact that some persons with mental illness do not

necessarily "seek" services, but are pressured to accept them (Pescosolido et al., 1998). When clinicians view a client's resistance to a psychiatric treatment recommendation as a by-product of the illness itself, they may deem that exercising authority (and, at times, paternalism) is justified to ensure a patient-centered and clinically effective approach.

Exercise of clinician authority in treatment decisions does not automatically connote a unilateral model in which patients are passive recipients of physician recommendations, however. For example, research conducted from an interactional perspective demonstrates that providers may modify their treatment recommendations in response to patient resistance (Hudak et al., 2011; Stivers, 2007; Toerien et al., 2013). In this way, as Toerien, Shaw, and Reuber (2013) argue, "authority is, at least somewhat, influenced and tempered by the actions of the patient" (p. 874). In treatments for chronic conditions, moreover, participation in decision making may more fruitfully viewed as a process which may unfold over the course of an encounter, or even multiple encounters (Say et al., 2006) and, in the case of psychiatric disorders, is inextricably tied to the context of an ongoing therapeutic relationship (Matthias et al., 2013). In this sense, everyday psychiatric practice may inhabit a middle ground between the egalitarian process idealized in SDM and the starkly authoritarian model of medicine to which SDM was designed to respond.

Understanding how such communicative processes unfold in actual interactions between psychiatric providers and their clients requires methods that capture these processes *in situ*. The methodology of Conversation Analysis (deployed here) enables us to see how practitioners' arguments for treatment decisions are designed in ways that both enact their decision-making authority and, at the same time, are responsive to client's preferences and concerns.

Prior conversation analytic research on treatment decisions

Conversation Analysis has been used extensively to examine the organization of activities that comprise medical visits, such as, patients' problem presentation, medical history taking, physical examination, delivery of diagnostic and prognostic news, and negotiation of treatment recommendations (e.g., Heritage & Maynard, 2006). This research has identified and described systematic ways in which patients and medical providers participate in medical decisions (Collins et al., 2005). A number of studies into treatment recommendation sequences have shown that even though it is medical providers who ordinarily make treatment recommendations, patients are actively involved in this stage of a medical consultation in that they are in a position to accept (or reject) the doctor's proposals (Koenig, 2011; Stivers, 2005b, 2006) and may even pressure physicians for particular treatments (Gill, 2005; Stivers, 2007). In other words, treatment decision-making is a bilateral process in which patients are more or less actively involved (Collins et al., 2005). These studies have also documented the fact that, if the patient does not accept a medical recommendation explicitly (e.g., by remaining silent following the proposal formulation, which is a form of passive resistance, or by questioning the proposal, a form of active resistance), medical providers may pursue acceptance of their recommendation by using a variety of conversational practices (Costello & Roberts, 2001; Koenig, 2011; Roberts, 1999; Stivers, 2005a, b). One of such documented practice is to *account* – i.e., to provide rationales, justifications, or explanations – for a treatment recommendation.

The sociological interest in accounts and accounting is long standing, in large part because accounts offer insight into members' common-sense reasoning about their world – what they see as accountable (i.e., in need of correction, justification, or explanation) and what sorts of accounts are seen as legitimate and intelligible (e.g., Antaki, 1994; Buttny, 1993; Harré et al.,

1985; Orbuch, 1997; Scott & Lyman, 1968; Shotter, 1984). An examination of accounting

episodes gives access to participants' understandings of social norms for acting and reasoning –

for instance, in medicine, what medical providers and patients may see as "good reasons" for

their medical decisions. Given the prominence of accounts and accounting in medicine,

surprisingly few studies have examined providers' use of accounts in interactions with their

patients (Parry, 2009). (For a study of patients' accounts, see Halkowski, 2006.) Prior research in

this area has analyzed *when* accounts are proffered (and less systematically what *sorts* of

accounts they are) and found that physicians' accounts play a role in two medical activities:

providing a diagnosis and proposing a treatment plan. When doctors provide accounts or

explanations for their diagnosis, they balance their medical authority with accountability,

suggesting that patients are capable of understanding medical matters (Peräkylä, 1998).

Physicians' accounts may be used prospectively – to build agreement and reduce incipient

patient resistance to a sensitive diagnosis (Maynard, 2004) and to pre-justify a particular

treatment recommendation (Costello & Roberts, 2001; Hudak et al., 2011). They may also be

offered retrospectively – to justify a proposed treatment in the face of patients' (active or

passive) resistance (Costello & Roberts, 2001; Koenig, 2011; Roberts, 1999; Stivers, 2005a, b).

While this research has provided valuable insights into communicative processes through

which medical treatment decisions are achieved in interaction, up to now, a majority of this work

has examined primary care visits (e.g., Gill, 2005; Koenig, 2011; Stivers, 2005b, 2006, 2007)

and a small number of specialty care settings, such as, oncology, neurology, and diabetes (e.g.,

Collins et al., 2005; Koenig et al., 2014; Roberts, 1999; Toerien et al., 2011; Toerien et al.,

2013). Furthermore, most of the studies have focused on treatment recommendations in acute

rather than chronic care visits. The present study begins to fill the gaps in our understanding of

the treatment recommendation phrase by exploring the interactional processes involved in treatment decision making in ongoing, long-term psychiatric care, adding to a small but growing body of conversation analytic literature on psychiatry (e.g., Bergmann, 1992; McCabe et al., 2013; McCabe et al., 2002; Quirk et al., 2012).

<u>The setting: Assertive Community Treatment</u>

This study examines communication in an assertive community treatment (ACT) program, a commonly used team model of intensive case management for people with serious and prolonged psychiatric disorders such as schizophrenia and bipolar disorder (Allness & Knoedler, 2003; Stein & Santos, 1998). ACT programs provide intensive, comprehensive community-based support via an interdisciplinary treatment team, frequently including social workers, nurses, psychologists, and a psychiatrist. Several features of the model are distinct from traditional psychiatric treatment. First, treatment plans are tailored to client needs, incorporating medication management, training in everyday life tasks, supportive psychotherapy, and assistance with gaining disability benefits and housing. Second, many services are provided primarily via mobile outreach (clients' homes, workplaces, etc.), rather than in an office-based setting, to encourage more accurate assessment of needs and to obviate the need for clients to transfer learned skills to a novel environment. Third, ACT programs provide services in a time-unlimited manner, and thus treatment relationships are frequently carried out over multiple years or even decades. Finally, a hallmark of the model is the assertiveness of efforts to offer services to clients, even if they exhibit reluctance or ambivalence about treatment.

Within the ACT model, as in psychiatric treatment more generally, medications are a cornerstone of treatment and are provided via a long-term relationship with a psychiatrist, who is often employed directly by the program. Within the particular treatment model studied here

(assertive community treatment), psychiatric appointments are scheduled at regular intervals as part of the program's comprehensive medication support function, which frequently includes procurement and daily delivery of medications to clients in addition to prescribing and monitoring activities (Allness & Knoedler, 2003). While the explicit purpose of these appointments is medication management, psychiatrists working within ACT tend to adopt a generalist orientation to treatment that involves discussing with clients lifestyle issues (such as living arrangements, family relationships, and work activities) in addition to the medication regimen. Because of the variable course of serious mental disorders, psychiatry appointments serve to monitor the client's stability and responses to medication, and to make adjustments to the medications in order to optimize the client's capacity to cope with the illness and pursue personally determined psychosocial goals. The paper will analyze how interactional practices of accounting are used by psychiatrists to advance the goal of achieving consensus with clients about such medication adjustments.

Data and Method

The data were collected in 2009-2010 in an established ACT program in a mid-sized city. The data corpus used for this analysis consists of 36 audio-recorded naturally-occurring interactions between clients and a team psychiatrist, each between 15 and 45 minutes long. Treatment relationships are well-established in this program, with clients having been in the program for 12 years, on average.

The research protocol received Institutional Review Board approval and was likewise approved by the research review board of the organization that housed the ACT program. A convenience sample of 36 clients was recruited by distributing study information sheets to clients

during case management appointments and in the waiting area of the program. Clients who expressed interest in participating were instructed to attend drop-in meeting hours with research staff to complete informed consent procedures. Data were gathered via audio-recording one case management appointment and one medication check appointment with the team psychiatrist, who provided primary psychiatric services to all clients in the program (only the psychiatry appointment recordings were used in the analysis presented here). Informed consent was obtained from both client and provider participants, which included permission for the relevant provider to tape the session as it occurred.

The audio-recorded consultations were analyzed using Conversation Analysis, an inductive methodology that examines the organization of social interaction, including how conversationalists accomplish social actions in their interactions with others (Sidnell & Stivers, 2013). Audio-recordings of the psychiatric visits were transcribed following the standard conversation analytic transcription conventions (Hepburn & Bolden, 2013). All names and other identifiers on the transcripts are pseudonyms. In accordance with conversation analytic methods, sequences of interactions in which psychiatrists and clients discuss possible changes in psychiatric medications were identified and then analyzed case by case in order to elucidate recurrent interactional practices through which participants reach treatment decisions. For this article, we examined composition and sequential features of practitioners' justificatory accounts for their treatment recommendations. The data excerpts included in the article are representative of the corpus and were selected for their clarity; multiple instances of all analytic categories were found in the data. Instances of accounting for treatment recommendations were found in all consultations where a medication decision (a change in dose or type of medication) was discussed (24 out of 36 visits).

Analysis

Observations on the overall organization of medication check visits

The psychiatric visits analyzed for this study have an explicit institutional agenda as "medication check" appointments. While other topics are typically discussed (e.g., the client's living arrangements, family relationships, and work activities), the medical agenda is evident throughout the visit (cf. Robinson, 2004). Given the great heterogeneity between clients and across the course of the illness, the psychiatrist may take a more or less active role in directing the interactional agenda, depending on whether the client is exhibiting symptoms (e.g., actively hallucinating) or cognitive impairments that affect their participation in the interaction. Early in a typical visit, the psychiatrist asks a series of probing questions into "how things are" – how the client is feeling, thinking, sleeping, etc. These questions – not unlike history taking in other kinds of medical interactions – serve to evaluate (among other things) how well the medications are working, both therapeutically to control the client's psychiatric symptoms and in terms of the harmful side effects.

Following this diagnostic evaluation stage, possible changes in the treatment plan – i.e., whether (and how) to modify doses or types of medication the client takes – may be discussed. In our data, these discussions are ordinarily extensive and may take up a significant portion of the visit. If in acute primary care encounters, the treatment phase may consist of two turns – the physician's recommendation followed by the patient's brief acceptance (Stivers, 2006) – in the medication check appointments in our corpus this is never the case. While much more research is needed to analyze the organization of the treatment phase of a psychiatric visit (Bolden & Angell, 2015), some preliminary observations will help situate the findings presented here.

A number of different trajectories are possible, depending on who (the psychiatrist or the client) initiates the discussion of a possible medication change. First, following the diagnostic questioning phase of the visit, the psychiatrist may begin to build a case for a medication change. The psychiatrist may formulate her evaluation of how well the client is doing in a way that prepares the ground for a particular recommendation. The psychiatrist may then float the idea of a medication change by, for example, explaining the therapeutic effects of a particular medication (cf. Toerien et al., 2013). Once this information is provided, the psychiatrist may propose a medication change and solicit (more or less directly) the client's in-principle agreement to the change. The psychiatrist may then consult the client's medical records (e.g., test results, medication history, etc.) and propose a specific implementation plan (such as, the exact dosages and timeline for implementing the change). The client's acceptance of the plan is then sought and may be explicitly solicited (and re-solicited) at multiple points. Alternatively, the client may be the one who initiates the discussion of a medication change by, for example, directly requesting a change in the regimen or, less directly, by reporting a medication side effect problem. These requests may occur at the beginning of the visit or later, during the treatment discussion. The client's request may instigate diagnostic questioning, and the psychiatrist will eventually respond by either rejecting the request or proposing some alternative plan (e.g., re-evaluating the situation at a subsequent visit or reducing the dosage rather than eliminating the drug altogether). An acceptance of the alternative plan is then sought from the client.

These observations about the unfolding of treatment discussions reveal that, even though in this setting the psychiatrist is institutionally authorized to make medication decisions, participants orient to achieving consensus about the treatment plan. To this end, the psychiatrist employs an array of interactional practices to account for, justify, and explain a particular course

of treatment. Our analysis shows that the psychiatrist's accounts are deployed in the following interactional contexts: First, accounts are provided when a psychiatrist's proposal is met with active or passive resistance from the client (Koenig, 2011; Stivers, 2005b, 2006), i.e., when the client does not (immediately) accept the psychiatrist's proposal but instead remains silent (passive resistance) or questions or rejects the proposal (active resistance). In such cases, accounts may be used to pursue acceptance of the psychiatrist's treatment proposal (see Excerpt 2 and Excerpt 5 below). Second, accounts are given to ground a refusal of a client request (cf. Robinson & Bolden, 2010; Schegloff, 2007), such as, a request for a new medication or a medication dose decrease (see Excerpt 1, Excerpt 3, Excerpt 4, and Excerpt 6 below). Third, accounts may be given by the psychiatrist in an attempt to forestall an incipient resistance to an upcoming proposal of a medication change (especially, an increase in dosage of antipsychotic medications which is often resisted by clients) during the diagnostic evaluation stage or as part of building a case for an upcoming recommendation (cf. Costello & Roberts, 2001) (see Excerpt 7 below). In the interests of space, here we only examine accounts given as part of the medication regimen discussion; accounts produced in the diagnostic stage of the visit are subject of a separate manuscript.

Two types of psychiatrists' accounts

In this section, we introduce two broad types of accounts psychiatrists may employ to forge agreement about a medication plan with the client. These are: *client-attentive* accounts, which display an orientation to the client's medical concerns or emotional needs (cf. Hudak et al., 2011); and *professional authority* based accounts, which draw upon an asymmetry between the two parties with respect to professional expertise and institutional legitimacy (cf. Pilnick & Dingwall, 2011).

The interactional deployment of these two types of accounts is illustrated in Excerpt 1.

Earlier in the consultation, the client (CLT) had complained of an uncomfortable tremor, a

common side effect of several medications. Near the end of the visit, the psychiatrist (PSY)

summarizes the plan of action (lines 1-2), which is to lower the dose of a mood stabilizing

medication (Depakote). In line 3, the client asks about another mood stabilizing medication she

is taking, Lithium. The psychiatrist treats the inquiry as a request to lower the dosage of Lithium

and rejects it ("I'd keep that where it is"; line 4). Our focus is on how the psychiatrist accounts

for or justifies her rejection of the client's request.

Excerpt 1: 205P (28:40)

```
1     PSY:  An' we'll lower the Depakote, and just see:
2           like over the nex:t [several weeks]
3     CLT:                      [What    about]the:: uh Lithium.
4     PSY:  .h I'd keep that where it is, cause it's a
5           running low anyway?
6           (.)
7     PSY:  It's al[ready low
8     CLT:         [(wha:t eh:)
9     PSY:  The level is low.<I'm thinking your tremor
10          by the way you described it is more due to
11          the Depakote anyway? .h
12    CLT:  Go[:(tch)/(d)
13    PSY:    [an' because it was running (.) pretty hi::gh,
14          it's even more likely ↑to be due to the Depakote?
15          (1.0)/{.hhh}
16    PSY:  Jus by the way you're >describing it.An'<
17          the Lithium level's low.It's point fou:r, an'
18          (an' we-) (.) that's like- (0.2) low enough
19          that (.) we'd be nervous about #lowering that.#
20          (0.2)
21    PSY:  But the Depakote can go down 'n' (.)
22          that's very likely to make that
23          °tre[mor go away°        [(°°so:°°)
24    CLT:      [↑I don't remember g[etting↓ three
25          Lithium.
```

In building her account for the rejection, the psychiatrist refers to the plasma

concentration of lithium in the client's bloodstream, as indicated by lab work ("running low"; in

lines 4-5, 7, and again 9). (Having the plasma concentration of a medicine outside the suggested

range – i.e., low or high – is a sign that the medicine dosage needs to be adjusted.) By bringing

up this "scientific evidence" (blood test results) in support of her treatment recommendation, the

psychiatrist enacts her *professional medical authority* as somebody who has access to and is able

and authorized to interpret (e.g., as "running low") medical tests. The psychiatrist references

blood levels multiple times in this segment, both to justify her recommendation to lower

Depakote (which is "running (.) pretty hi::gh"; lines 13-14) and *not* lower Lithium (lines 16-17).

In lines 21-22, the psychiatrist formulates her prognosis about the likely outcome of lowering

Depakote (eliminating the tremor), which is also a justificatory account based in the

psychiatrist's professional expertise and authority to project medication effects.

Aside from these kinds of professional authority based accounts, the psychiatrist also

uses *client-attentive accounts*, which portray medical recommendations as grounded in the

clients' concerns and/or emotional needs. For example, in line 9 (and again in line 16), the

psychiatrist explicitly references the client's earlier description of the tremor, attributing her

decision to lower Depakote (rather than Lithium) to the details of the client's description ("your

tremor by the way you described it", lines 9-10). This formulation presents the recommendation

as tailored to and directly arising from the client's expressed concerns (rather than being driven

only by the blood work, for example). The use of client-centric accounts is consistent with

guidelines in psychotherapy and medicine that emphasize the importance of eliciting and

responding to the patient's unique experiences and perspectives (Norcross, 2002; Priebe et al.,

2011).

Excerpt 1 thus illustrates how the psychiatrist deploys both client-attentive and

professional authority based accounts to justify her rejection of the client's request. While the

psychiatrist may intertwine these two types of accounts in pursuit of agreement from the client

(see the Discussion section below), in the following sections we examine each type in turn, starting with the client-attentive accounts.

Client-attentive accounts

In this section, we examine how a psychiatrist displays an orientation to clients' needs and concerns in accounting for a particular treatment recommendation. These include: accounts that cite the client's previously stated concerns as grounds for a particular medical decision and accounts that convey the psychiatrist's caring stance towards the client.

Citing client concerns

In formulating a treatment recommendation as arising from and thus tailored to clients' own concerns, a psychiatrist displays attentiveness to the client's needs (cf. Hudak et al., 2011). To justify her recommended treatment plan, the psychiatrist may cite an issue mentioned by the client as problematic, which may involve reusing the words the client used in describing the problem. This sort of "overt linking" to the client's own words may increase pressure on the client to affiliate with the psychiatrist's position (Parry et al., 2014; Peräkylä, 1995).

In Excerpt 1 (introduced in the previous section), the psychiatrist explicitly references the client's formulations of concerns in pursuit of the client's acquiescence to a treatment plan. As noted above, the client asks about lowering Lithium (line 3), and the psychiatrist rejects the request (line 4) and then accounts for her rejection by referring to the blood tests (lines 4-5). When the client does not respond (see the short gap in line 6), this account is re-iterated twice (lines 7 and 9). The psychiatrists then shifts her line of argument, and explicitly references the client's earlier description of the tremor, attributing her decision to lower Depakote rather than Lithium to the details of the client's description ("your tremor by the way you described it", lines 9-10). (Note that Lithium and Depakote each may produce hand tremors as side effects; Canning

et al., 2012). In overlap with the client's response (which indicates some kind of acknowledgement but is barely audible on the recording; line 12), the psychiatrist extends her account by bringing up the Depakote blood levels ("running (.) pretty hi::gh"; line 13). The client again fails to respond to this explanation (see the 1.0 sec gap in line 15), and the psychiatrist extends her turn to again reference the client's description of the tremor ("just by the way you're describing it"; line 16). So here we can see how the psychiatrist shifts from an account grounded in her medical authority to a client-attentive one in an attempt to secure the client's support for a particular medication decision.

Excerpt 2 provides another illustration of this practice. Earlier in the visit from which this excerpt is taken, the client complained about hearing voices that remind him to do daily tasks (e.g., brush his teeth, take showers, etc.), and the psychiatrist had proposed raising Lithium and Zyprexa dosages. Even though the client initially agreed with the plan (data not shown), when the psychiatrist again suggests raising Zyprexa (lines 1-2; 4-5), the client remains silent (see the gaps in lines 3 and 6), which could indicate the client's resistance to the proposed raise. The psychiatrist goes on to justify her recommended course of treatment by formulating a potential positive outcome of the medication on the client's symptoms (lines 7-10). In her justification, the psychiatrist explicitly cites the client's earlier descriptions of the "reminders" and the "voices" ("reminders in your head" and "the voices you are describing"; lines 9-10), thus formulating her recommendation as directly responsive to the client's stated concerns.

Excerpt 2: 203P (21:05)

```
1    PSY:  I think maybe right no:w just
2          in the shor:t run a little more Zyprexa might help,
3          (0.5)
4    PSY:  Uh:m: (0.2) you could go from twonny five to thirty:
5          just- (.) to see how things go.
6          (1.0)
7    PSY:  An' then we can see if that- (.) makes a d:ifference,
8          kinda ca:lms down some of those (1.0)
```

```
9            like reminders in your head, h an' the voices
10           you were describing, an:' (.) an' then if it doesn't,
11           (0.5)
12    PSY:   What were you smiling about there for a second.
             ((shift topic))
```

Thus, in both of the discussed excerpts, the psychiatrist deploys accounts that present her medication treatment plan as arising from and tailored to the client's own presented concerns. These accounts are proffered in environments where the client may be seen as (passively) resisting the psychiatrist recommendation for or against a particular medication change. We now turn to accounts that convey the psychiatrist's caring for the client's well-being.

Enacting a caring stance towards the client

In psychiatry, it is commonly acknowledged that a positive working relationship with clients is essential for promoting their cooperation in treatment plans (Blackwell, 1997; Turkington et al., 2006). Psychotherapy research has shown that certain practitioner attributes and behaviors are successful in fostering effective psychotherapy relationships, and among these are empathic communication and what psychotherapy researchers term "positive regard," which refers to projecting warmth and caring toward the client through both behavior and attitude (Farber & Doolin, 2011). Our analysis documents how psychiatrists' enactment of concern for the clients' well-being, which often index the psychiatrist's knowledge of the client's long-term history, may be deployed to justify their medication decisions and to pursue consensus about a treatment plan.

Assertions of caring may be used to counter medication changes proposed by clients. In Excerpt 3, the client requests a reduction in Zyprexa, an antipsychotic medication, to a level he had been on previously (lines 1-3). The psychiatrist says that it is too soon, thereby rejecting the request for the time being (lines 4-5). Even though the client agrees with the psychiatrist's plan to assess the situation at a later time (lines 6-12), the psychiatrist goes on to justify the

postponement by projecting that a reduction will cause the client to feel worse, as he had before

the most recent increase (lines 13-21). This reference to the client's past psychiatric status and

life events (e.g., him "leaving") evidences and invokes the longitudinal nature of their

therapeutic relationship. Then, in closing the explanation, the psychiatrist expresses her concern

for the client's well-being (with an emphatic "I do worry about #that.#" in line 23).

Excerpt 3: 204P (22:40)

```
1    CLT:   [An'] then doctor y'all: uh: h (0.5) talk
2           you guys will talk about getting me
3           back down then on the Zyprexa¿
4    PSY:   Yeah. But I do think it's a little bit early
5           for tha:t¿
6    CLT:   [Okay
7    PSY:   [if we don't have to¿ So I would say (0.2)
8           we should do is meet agai:n, (.) y'know
9           maybe in another week Micah?
10   CLT:   O:kay.
11   PSY:   to see how you're doin'¿
12   CLT:   °Yeah.°
13   PSY:   Uh::m becaus:e (0.8) if you needed it (.)
14           to do better before you le:ft, (0.5)
15           >it's been a very< short time since you've
16           been go:ne, (.) a::n:' it's likely if we go
17           back down to the twonny, that you'll (0.2)
18           feel:=like you were before ya left,
19   CLT:   Yeah.
20   PSY:   An::' that (0.5) wasn't the right feeling
21           at least [for you at that time.
22   CLT:            [Yep.
23   PSY:   so I do worry about #that.#=
24   CLT:   =O:kay.
25   PSY:   An' I think all'f this may be adding
26           toge:the:[r¿ to make you feel really °°cra(h)pp(h)y°°
27   CLT:            [Yeah:,
28   CLT:   Yeah.
29   PSY:   An' so I am concerned about it.
30           But- (0.5) uh:: (1.2) I think the first step
31           is trying to find out (0.2) y'know
32           what's going out with the Niaspan, so [in case
33   CLT:                                          [Okay,
```

Following the psychiatrist expression of "worry" (line 23), the client appears to accept the

psychiatrist's account for postponing a dosage decrease ("O:kay." in line 24). The psychiatrist

then goes on to enact an empathic stance towards the client's situation (lines 25-26), which in

effect tacitly validates the grounds for the client's request ("all'f this" in line 25 refers to the client's sleep problems which may have both physiological and psychiatric causes). Note that the psychiatrist characterizes the client's situation with the colloquial expression "really °°cra(h)pp(h)y°°" (infusing it with laughter, line 26), which appears to be a method for relating to the client's experience on a human (vs. professional) level (cf. Goffman, 1981). By "doing being real" via this shift in register, the psychiatrist enacts the therapeutic principle of congruence or genuineness, recognized as an important component of an effective psychotherapy relationship (Kolden et al., 2011). She then goes on to reiterate (again, emphatically) her concern about the client's situation as a basis for her decision (line 29). In these ways, the psychiatrist presents her decision (to postpone the requested medication decrease) as grounded in her concern and caring for the client's well-being.

The psychiatrist uses similar practices (references to the client's history, assertions of caring, and colloquialisms) in Excerpt 4. Leading into this segment, on the client's request, the client and the psychiatrist discuss the possibility of changing the client's current medication regimen (e.g., increasing anti-anxiety medications and/or changing antipsychotic medications), and the psychiatrist is making the case for keeping the medications unchanged. The client had previously had medical problems related to her drug addiction, which makes medication changes particularly difficult. In lines 1-2, the psychiatrist begins to formulate a proposal for a possible medication change ("we could do: (.) an alternative antipsycho-"), but then cuts herself off (indicated on the transcript by a dash on "antipsycho-") before the proposal is fully out and asserts her apprehension about implementing any change.

Excerpt 4: 227P (23:45)

```
1    PSY:  So: (.) yeh- we could do: (.) an alternative
2          antipsycho-=y'know I'd feel ↓nervous °as hell
3          about changing anything.°
```

```
4           (0.4)
5    CLT:  t!=I kno[w.
6    PSY:        [y'know. (.)
7          It's scary (.) as a:ll get out to change anything.=given
8          what you've been through.
9          (.)
10   PSY:  over the last- (.) coupla years. y'know,
           ((psychiatrist checks medical records for current blood levels))
```

In justifying her inclination to keep the medications unchanged, the psychiatrist enacts a caring

stance towards the client: "I'd feel ↓nervous °as hell about changing anything.°" (lines 2-3).

While producing this account, the psychiatrist shifts into a conspiratorial – "between you and

me" – tone of voice (note the downward pitch shift, marked by the arrow, and a quiet voice,

marked by the degree signs) and colloquial register ("as hell"). Again, this expression of the

psychiatrist's own apprehension resonates with the notion of genuineness ("doing being real"),

believed by psychotherapy researchers to be essential to an effective therapeutic relationship

(Kolden et al., 2011). Following the client's endorsement of the psychiatrist's reservations ("I

know" in line 4), the psychiatrist extends her account with a further, upgraded enactment of a

caring stance, again using a colloquial expression ("scary (.) as a:ll get out"; line 6) to formulate

her feelings about the change. The psychiatrist then enacts an empathic stance towards the client

by invoking the client's troubling history ("what you've been through. (.) over the last- (.) coupla

years."; lines 7-9). By bringing up the past, the psychiatrist claims to know and remember what

the client has "been through," thereby using their long-term relationship as a resource in the

service of strengthening her argument for not changing the medications.

        In this section, we have examined a range of client-attentive accounts a psychiatrist may

deploy in an attempt to foster agreement with the client about a treatment plan. We have seen

that these accounts may be used in environments when consensus is in question: to overcome

clients' (active or passive) resistance to a medication change recommendation (as in Excerpt 2)

and to justify rejecting a client's request for a medication change (Excerpt 1, Excerpt 3, and Excerpt 4). Client-centric accounts may be used in combination with other practices that rely on and invoke the psychiatrist's professional expertise, as discussed in the following section.

Professional authority based accounts

Psychiatrists may account for their treatment recommendations by grounding their decisions in their professional expertise, using the disparity in medical knowledge and professional training between the client and the clinician as a resource (cf. Peräkylä, 1998). In justifying their recommendations, psychiatrists may enact their professional expertise by making a prognosis about the client's future state in light of a proposed treatment plan and by categorizing the client's experiences as either "normal" or symptomatic of their mental illness. Psychiatrists' enacted expertise thus becomes a source of leverage in convincing the client to take part in a proposed treatment plan (Blackwell, 1997).

Prognostic formulations

Diagnostic and prognostic evaluations are the hallmark of the asymmetry that persists between provider and client expertise in medical settings: Clients' subjective experiences are elicited and interpreted through a medical lens to produce an authoritative assessment (e.g., Maynard, 1991; Pilnick & Dingwall, 2011). In the setting studied here, clients' psychiatric diagnoses are already well established, yet diagnostic assessments of changes in psychiatric status are continually rendered and updated. This process involves what Longhofer and Floersch (2004) term medication effect interpretations, in which providers judge to what degree medications are optimized. As mentioned above, medication check appointments typically begin with a series of probing questions into how the client is doing (similar to history taking in other kinds of medical interactions). On the basis of the client's responses and other available evidence

(such as blood tests, reports from other team members, etc.), the psychiatrist proffers a diagnostic and prognostic evaluation of the client's current status and then uses it as grounds for subsequent treatment recommendations.

As the instances below show, psychiatrists' recommendations for or against a particular treatment decision may be justified by projections of their (beneficial or harmful) consequences. Such projections are often formulated with references to the client's psychiatric history and previous medication changes. For instance, in Excerpt 3 (analyzed above; a partial transcript is reproduced below), the client requests a medication dosage reduction (lines 1-3), and the psychiatrist rejects the request (lines 4-5) and suggests reassessing the situation at a later time (lines 6-12). The psychiatrist then produces an account for the postponement by formulating a likely negative outcome to the requested dosage reduction: "you'll feel:=like you were before ya left" (lines 17-18). The client agrees with the account ("Yeah" in line 19).

```
Excerpt 3(partially repeated): 204P (22:40)

1     CLT:  [An'] then doctor y'all: uh: h (0.5) talk
2           you guys will talk about getting me
3           back down then on the Zyprexa¿
4     PSY:  Yeah. But I do think it's a little bit early
5           for tha:t¿
6     CLT:  [Okay
7     PSY:  [if we don't have to¿ So I would say (0.2)
8           we should do is meet agai:n, (.) y'know
9           maybe in another week Micah?
10    CLT:  O:kay.
11    PSY:  to see how you're doin'¿
12    CLT:  °Yeah.°
13    PSY:  Uh::m becaus:e (0.8) if you needed it (.)
14          to do better before you le:ft, (0.5)
15          >it's been a very< short time since you've
16          been go:ne, (.) a::n:' it's likely if we go
17          back down to the twonny, that you'll (0.2)
18          feel:=like you were before ya left,
19    CLT:  Yeah.
```

Prognoses of harmful consequences of a medication change may be used to bolster the psychiatrist's argument when other kinds of accounts are met with resistance. Excerpt 5 is a rare

instance in which the client overtly rejects the psychiatrist's justification for a treatment decision.

Prior to this segment, the client had requested a sharp decrease in the dose of his antipsychotic

medications, arguing that the recent raises had been unfounded. The psychiatrist rejected the

request and is now attempting to justify her decision to keep the medications at the current level.

In her account, she uses a number of different interactional practices we have discussed,

including enacting a caring stance towards the client ("th:ings… were really hard on you:"; lines

1-3) and citing evidence in support of the diagnostic assessment of the client's past state (as

irritable, angry, problem sleeping, and "really wo:rried"; lines 8-15) in a client-attentive way,

which treads on the client's epistemic territory ("more so than you even seem to want¿"; lines

10-11). Once the client begins a response that clearly projects a rejection of the psychiatrist's

account (lines 17 and 19), the psychiatrist extends her turn (in competition with the client's) to

amend the list of symptoms (which might be seen as falling into a category of "normal"

behavior) to include more obviously medically actionable items: worrying about "the demo:ns,

an' the (.) ghosts" (lines 20-21).

Excerpt 5: 211P (6:20)

```
1     PSY:   we did see th:ings going o:n
2            tha:t:hh (0.8) uh we were concerned about
3            that- we thought were really hard on you:.
4            (.)
5     PSY:   y'know, (0.2) when- (.) when we raised >the meds.It<
6            wasn't just because'f the gu::y, (0.5)
7            it was because we were seeing other stuff too,
8            <like a- a lo:t a lo:t'av l- uhm kinda irritabl:e,
9            (0.8) uh:: (0.8) th' irritabl:e, >y'know< angry,
10           .hhh kinda feelings¿ coming out¿ more so
11           than you even seemed to want¿
12           (0.2)
13    PSY:   Uh::m (1.0) problem sleeping,=at ti::mes:¿
14           (0.5)
15    PSY:   uh:m (1.0) getting really wo:rried¿
16           (0.2)
17    CLT:   That don't mean-=
18    PSY:   =about stuff that=
19    CLT:   =All that stuff you j[ust sain'
20    PSY:                        [the demo:ns, an'
```

```
21          th[e  (.)      [ghosts,
22   CLT:     [All that st[uff you just sa:id. (.) don't mean
23          I have to stay on 'at dos:e.
24          (1.0)
25   PSY:   We:ll, (2.0) what- what we fi:nd is usually:
26          if- (0.8) if a person needs a higher dose
27          to get rid of some of ↑that stuff? (0.8)
28          ↓that (.) if we lo:wer the dose back down
29          that stuff will come back.
30   CLT:   No it [won't.
31   PSY:         [It doesn't like cu:re it.
32          (.)
33   PSY:   It only: (0.2) So that's how we find out how much
34          a person nee:ds. is gradually increasing it little by little
35          over time,
```

The client, however, persists in rejecting the psychiatrist's explanation as a valid reason for keeping the medications at the current dosage (lines 22-23). In response, in lines 25-29, the psychiatrist produces another type of account in which she formulates a likely possible outcome of lowering the dose: "if we lo:wer the dose back down that stuff will come back" (lines 28-29). While this prognostic formulation is directly applicable to the client's current situation, the account is produced in generic terms (in reference to "a person"; line 26) and invokes the psychiatrist's medical authority as a representative of the institution (the use of the "institutional *we*"; lines 25 and 28) (Angell & Bolden, forthcoming; Drew & Heritage, 1992). So here, in the face of open resistance from the client, the psychiatrist moves from a client-attentive, particularized reasoning to an account that is entirely within the psychiatrist's epistemic domain. The client again rejects this reasoning (line 30), and the psychiatrist continues with an institutional, medical explanation of how antipsychotic medications work (lines 31-35). In the two excerpts above, then, the psychiatrist uses both her medical authority and the history of the therapeutic relationship with the client to piece together seemingly disparate pieces of information about the client into a coherent account of medication effects so as to justify a treatment recommendation.

Categorizing clients' experiences in psychiatric terms

One central issue in psychiatry is whether a behavior or a set of behaviors is a psychiatric symptom (controlled/treatable with medications) or whether it falls within a range of "normal" behaviors that are not subject to medical treatment (cf. Antaki et al., 2005). The process of medicalization occurs at an interactional level when physicians or other medical authorities adopt a medical frame to interpret and act on a particular behavior. Conversely, classification or reclassification of a questionable or deviant behavior as normal is termed demedicalization (Conrad, 1992). In building a case for a particular medical regimen, a psychiatrist may formulate behaviors the clients report (or that she observes directly) in ways that convey (explicitly or tacitly) this distinction. Behavior formulations rely on what Sacks (1972a, b) called "membership categorization analysis": They are selected for their association with a particular identity category ("psychiatric patient" vs. "normal person") in the service of the implemented action (i.e., justifying a particular medical decision). Thus, behavior descriptions can be "normalized" when the psychiatrist argues against prescribing (or increasing) a medication or, alternatively, "medicalized" when the argument is made for the necessity of a medication (or dosage increase).

Excerpt 6 illustrates the use of normalization of a client concern as an account for declining the client's medication change request. Prior to Excerpt 6, the client requested an increase in Prozac to address depression and anxiety. The psychiatrist has been building a case against this increase by asserting that what the client experiences is not a clinical depression that can be addressed with more Prozac (data not shown). In line 1, the psychiatrist again rejects the request, explaining that the decision is complicated by the fact that the client is going through withdrawal from stimulants, which she had been abusing (and needs "more clea:n time"; line 2).

Excerpt 6: 227P (14:35)

```
1    PSY:   .hh So: (.) I'm not really comfortable raisin' that dos:e.
2           I mean I think you need more clea:n time.
3           (0.2)
4    PSY:   uh to see-=to give it time to come around on its o:wn.
5           (0.2)
6    PSY:   °Y'know:¿°=.h This is (.) a predictable thing
7           for somebody coming off: (0.2) stimulants.
8           (0.2)
9    PSY:   This: crashi:ng, an' (0.2) for: (0.2) months even.
10          (.)
11   PSY:   Y'know¿
12   PSY:   .hhh Uh:m (0.5) so (0.5) °#I really don't think
13          it's gonna make a difference,#°
14          (.)
```

In lines 6-7, the psychiatrist refers to the client as "somebody coming off: (0.2) stimulants,"
thereby putting the client into the membership category of recovering addicts (and tacitly
rejecting the applicability of the "clinical depression" label). In this way, the symptoms are
normalized (any person coming off drugs would feel this way) and separated from a
treatable/psychiatric condition. The psychiatrist goes on to describe the client's experiences as
"crashi:ng" (line 9), which again invokes a drug withdrawal problem (i.e., an activity
categorically bound to "drug addicts").

The psychiatrist may also formulate the client's behavior as comparable with other
people suffering from a mental illness (and thus medically actionable) in order to justify a
medication increase. In Excerpt 7, the psychiatrist begins to build a case for raising the dosage of
Zyprexa (lines 11-13). In lines 1-8, the psychiatrist suggests that the voices the client has
complained about earlier in the visit (data not shown) are part of the symptoms of his
schizoaffective disorder. In building her case for a medication increase, the psychiatrist compares
the client to other people with this disorder who "c:ycle" (line 6) or "have cycles of symptoms"
(line 8).

Excerpt 7: 215P (22:10)

```
1    PSY:    [Ehm the other thing, I think your diagnosis
```

```
2            isn't it schizoaffective disorder?
3    CLT:   Some[thing like that yeah] I heard that [before.
4    PSY:       [Something like that?]              [But the
5            affective pa:rt of that mea:ns that sometimes people
6            c:ycle.
7            (0.8)
8    PSY:   Y'kn[ow have cycles of symptoms,
9    CLT:       [(okay¿)
10           (0.5)
11   PSY:   A:n' during those times (.) I mean the meds thachu're o:n
12           (1.0) the: (.) the Zyprexa (.) is one med that can
13           kinda (.) put a lid on tha:t,
14           (1.0)
15   PSY:   (°m-°) those symptoms that they act up every once in awhile.
16           (.)
```

In this section, we have analyzed ways in which a psychiatrist enacts her professional expertise in accounting for her treatment recommendations. In these types of accounts, the client's individual experiences are recast as generic or typical of a particular population, and the psychiatrist's authoritative access to this generalized professional knowledge is used as leverage to justify a particular treatment recommendation. The analysis shows that authority based accounts may be used prospectively to build a case for a medication increase (Excerpt 7) and retrospectively in the course of rejecting the patient's request for a medication change (Excerpt 3, Excerpt 5, and Excerpt 6). These accounts bolster the psychiatrist's recommendation for or against a particular medical regimen and are rarely challenged by clients (but see Excerpt 5).

Discussion

In long-term psychiatric treatment, medication management is an ongoing process in which drug type and dosage are adjusted periodically to address changes in psychiatric symptoms and medication side effects. In this paper, we have shown that, even though the psychiatrist is granted the institutional authority to make medication decisions, she routinely justifies her recommendations to the clients using a variety of accounts to achieve consensus about the treatment plan. First, client-attentive accounts display the psychiatrist's attentiveness

and caring for the client and include accounts that present the treatment recommendation as fitted to the client's stated needs and concerns (Excerpt 1 and Excerpt 2) and express caring and concern for the client's well-being (Excerpt 3 and Excerpt 4). The analysis has shown how attentiveness to personal and relational aspects of client-provider communication, an important component of both psychotherapy and psychiatric treatment (Norcross, 2002; Priebe et al., 2011), represents a resource that may be deployed interactionally in justifying treatment plans.

A second type of accounts used to justify medication treatment recommendations relies upon the psychiatrist's medical authority and expertise. Physician authority is thought to be an American cultural phenomenon that traditionally resulted in patient compliance, obviating the need for justification and persuasion by the physician (Starr, 1982). As medicine has shifted to a patient-centered ideology, however, practitioners increasingly must attempt to develop consensus with their patients (see also Peräkylä, 1998). Accounts for treatment recommendations that contain discussions of medical tests (e.g. plasma levels), prognostic projections (Excerpt 3 and Excerpt 5), and categorical ascriptions of clients' symptoms (Excerpt 6 and Excerpt 7) invoke the scientific authority of the practitioner as an expert, while also displaying providers' orientation to getting patients to understand and agree to the proffered recommendation.

In this article we have documented how – and in what interactional contexts – psychiatrists account for their treatment recommendations. The analysis has shown that different kinds of accounts may be used within the same action sequence (and sometimes within the same turn), which raises the question of whether there is orderliness to their deployment. The data show that the psychiatrist may shift between different types of accounts (e.g., from conveying a caring stance towards the client to using professional expertise to formulate a prognosis), especially when their accounts are met with some kind of resistance from the client (e.g.,

Excerpts 1, 3 and 5). Note that client-centric accounts may be more vulnerable to resistance in that they tread on the client's epistemic domain (by addressing clients' own experiences; see Excerpt 5), while accounts that are based on professional authority – especially as expressed through the language of "scientific" tests, etc. – are less so. On the other hand, clinicians may see accounts that cite medical evidence as opaque to clients (e.g., Excerpt 1), and thus not as effective in explaining the bases for their treatment decisions. The choice of a particular account type appears to be sensitive a number of different issues, including the local sequential context (the course of action in progress), the available medical evidence (e.g., blood tests), the client's displayed competencies in the relevant domain, the history of the client-psychiatrist relationship, etc. Further research is needed to sort out the considerations involved in deploying particular kinds of accounts, their sequencing, and their fittedness to the course of action being implemented through them. As it stands, however, the article extends our limited understanding of the complex nature of treatment decision making in psychiatry and chronic care more generally.

While this analysis is one of the first efforts to characterize treatment recommendations in psychiatry using recordings of actual psychiatric visits, several limitations of the study should be acknowledged. Although assertive community treatment is a widely used treatment model for people with serious mental illness, the analysis presented here focuses only upon one program, and as such, only features the practices of a single psychiatrist employed by that program. Thus, our findings warrant further study with a wider spectrum of types of psychiatric practice and multiple practitioners. In addition, the use of audio recordings for examining face-to-face interactions is limiting because participants' non-vocal conduct and embodied activities (such as

working with medical records), which are undoubtedly important features of clinical interaction, are unavailable to the analysts.

The paper has shown that accounts, whether designed to accentuate attentiveness to client needs or medical authority, are deployed as part of a negotiation process in which the clinician responds to client concerns, anticipates and counters resistance, ultimately leading to a client accepting or agreeing a treatment recommendation so that a corresponding treatment plan may be implemented. Analyzing the resources used by practitioners in this negotiation process, as we have done here, provides insight into how psychiatric providers pursue agreement on medication decisions that accord with their own professional opinions, yet are sensitive to the client's concerns, needs, and illness trajectories (cf. Koenig et al., 2014).

The use of accounts to convince clients to accept a proffered treatment recommendation is arguably a form of persuasion that conforms poorly to the idealized vision of collaborative, deliberative decision making endorsed by the shared decision making movement. In this sense, the current study adds to a growing literature that suggests that this idealized view shared decision making is distant from standard psychiatric practice (Matthias et al., 2012; Quirk et al., 2012; Salyers et al., 2012) and may even contradict fundamental principles of the social order of medicine (Pilnick & Dingwall, 2011). Whether psychiatric practice can or should find ways to increase client control in decision making cannot be determined by studies such as this one. However, if, as Matthias et al. (2013) argue, what matters most is that decisions are carried out in the context of a trusting partnership between client and clinician, this study provides an illustration of how caring yet authoritative decisions might look in practice. We show how practices of accounting enable practitioners to tailor justifications of their treatment recommendations to the client's preferences and knowledge about treatments; and

concomitantly, to extend opportunities for clients to exercise agency (i.e. to accept, reject, and

question the accounts) even as practitioners enact their authority as prescribers.

References

Allness, D.J., & Knoedler, W.H. (2003). *A manual for ACT start-up: Based on the PACT model of community treatment for persons with severe and persistent mental illnesses*: National Alliance for the Mentally Ill (NAMI).

Angell, B., & Bolden, G.B. (forthcoming). Team work in action: Building grounds for psychiatric medication decisions in assertive community treatment. In M. O'Reilly, & J. Lester (Eds.), *Handbook of adult mental health: Discourse and conversation studies*. London: Palgrave Macmillan.

Angell, B., Matthews, E., Barrenger, S., Watson, A.C., & Draine, J. (2014). Engagement processes in model programs for community reentry from prison for people with serious mental illness. *International Journal of Law and Psychiatry*, 37(5), 490-500.

Antaki, C. (1994). *Explaining and arguing: The social organization of accounts*. London: Sage.

Antaki, C., Barnes, R., & Leudar, I. (2005). Diagnostic formulations in psychotherapy. *Discourse Studies,* 7, 627-647.

Barry, M.J., & Edgman-Levitan, S. (2012). Shared Decision Making — The Pinnacle of Patient-Centered Care. *New England Journal of Medicine,* 366, 780-781.

Bergmann, J.R. (1992). Veiled morality: Notes on discretion in psychiatry. In P. Drew, & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings* pp. 137-162). New York: Cambridge University Press.

Blackwell, B.E. (1997). *Treatment compliance and the therapeutic alliance*: Harwood Academic Publishers.

Bolden, G.B., & Angell, B. (2015, July 3-5). The organization of the treatment recommendation phase in psychiatric visits. Paper presented at the 5th International Conference on Conversation Analysis & Clinical Encounters, Loughborough, UK.

Brodwin, P. (2013). *Everyday ethics: Voices from the front line of community psychiatry*: University of California Press.

Buttny, R. (1993). *Social accountability in communication*. Newbury Park, CA: Sage.

Canning, J., Burton, S., & Hall, B. (2012). Lithium and Valproate-induced tremors. *Ment Health Clin,* 1, 19.

Carter, M. (2003). The relationship of a self-reported assessment of need in mental illness to insight. *Journal of mental health,* 12, 81-89.

Charles, C., Gafni, A., & Whelan, T. (1999). Decision-making in the physician–patient encounter: Revisiting the shared treatment decision-making model. *Social Science & Medicine,* 49, 651-661.

Collins, S., Drew, P., Watt, I., & Entwistle, V. (2005). 'Unilateral' and 'bilateral' practitioner approaches in decision-making about treatment. *Social Science & Medicine,* 61, 2611-2627.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology,* 18, 209-232.

Costello, B.A., & Roberts, F. (2001). Medical recommendations as joint social practice. *Health Communication,* 13, 241-260.

Drake, R., & Deegan, P. (2009). Shared decision making is an ethical imperative. *Psychiatric Services,* 60, 1007-1007.

Drew, P., & Heritage, J. (1992). Analyzing talk at work: an introduction. In P. Drew, & J.

    Heritage (Eds.), *Talk at work: Interaction in institutional settings* pp. 1-65). New York:

    Cambridge University Press.

Epstein, R.M., Franks, P., Fiscella, K., Shields, C.G., Meldrum, S.C., Kravitz, R.L., et al. (2005).

    Measuring patient-centered communication in patient–physician consultations:

    theoretical and practical issues. *Social Science & Medicine,* 61, 1516-1528.

Farber, B.A., & Doolin, E.M. (2011). Positive regard. *Psychotherapy,* 48, 58-64.

Gill, V.T. (2005). Patient "demand" for medical interventions: Exerting pressure for an offer in a

    primary care clinic visit. *Research on Language and Social Interaction,* 38, 451-479.

Goffman, E. (1981). *Forms of talk*. Philadelphia: University of Pennsylvania Press.

Halkowski, T. (2006). Realizing the illness: Patients' narratives of symptom discovery. In J.

    Heritage, & D.W. Maynard (Eds.), *Communication in medical care: Interaction between*

    primary care physicians and patients (pp. 86-114). Cambridge, England: Cambridge

    University Press.

Harré, R., Clarke, D.D., & Decarlo, N. (1985). *Motives and mechanisms: An introduction to the*

    psychology of action. New York: Methuen.

Hepburn, A., & Bolden, G.B. (2013). The conversation analytic approach to transcription. In J.

    Sidnell, & T. Stivers (Eds.), *The handbook of Conversation Analysis* (pp. 57-76). Oxford:

    Blackwell.

Heritage, J., & Maynard, D.W. (Eds.) (2006). *Communication in medical care: Interaction*

    between primary care physicians and patients. New York: Cambridge University Press.

Hudak, P.L., Clark, S.J., & Raymond, G. (2011). How surgeons design treatment

    recoommendations in orthopaedic surgery. *Social Science & Medicine,* 73, 1028-1036.

Institute of Medicine Committee on Quality of Health in America. (2006). Improving the Quality

    of Health Care for Mental and Substance Use Conditions (pp. 77-139). Washington, DC:

    National Academies Press Report.

Koenig, C.J. (2011). Parient resistance as agency in treatment decisions. *Social Science &*

    Medicine, 72, 1105-1114.

Koenig, C.J., Wingard, L.M., Sabee, C., Olsher, D., & Vandergriff, I. (2014). Managing patient-

    centered communication across the Type 2 diabetes illness trajectory: A grounded

    practical theory of interactional sensitivity. *Journal of Applied Communication Research,*

    42, 244-267.

Kolden, G.G., Klein, M.H., Wang, C.-C., & Austin, S.B. (2011). Congruence/genuineness.

    Psychotherapy, 48, 65-71.

Longhofer, J., Floersch, J., & Jenkins, J.H. (2004). Medication effect interpretation and the social

    grid of management. *Social Work in Mental Health,* 1, 71-89.

Mahone, I.H., Farrell, S., Hinton, I., Johnson, R., Moody, D., Rifkin, K., et al. (2011). Shared

    decision making in mental health treatment: Qualitative findings from stakeholder focus

    groups. *Archives of psychiatric nursing,* 25, e27-e36.

Matthias, M.S., Salyers, M.P., & Frankel, R.M. (2013). Re-thinking shared decision-making:

    Context matters. *Patient Education and Counseling,* 91, 176-179.

Matthias, M.S., Salyers, M.P., Rollins, A.L., & Frankel, R.M. (2012). Decision making in

    recovery-oriented mental health care. *Psychiatric Rehabilitation Journal,* 35, 305-314.

Maynard, D.W. (1991). Interaction and asymmetry in clinical discourse. *American Journal of*

    Sociology, 97, 448-495.

Maynard, D.W. (2004). On predicating a diagnosis as an attribute of a person. *Discourse Studies,* 6, 53-76.

McCabe, R., Healey, P.G.T., Priebe, S., Lavelle, M., Dodwell, D., Laugharne, R., et al. (2013). Shared understanding in psychiatrist-patient communication: Association with treatment adherence in schizophrenia. *Patient Education and Conseling,* 93, 73-79.

McCabe, R., Heath, C., Burns, T., & Priebe, S. (2002). Engagement of patients with psychosis in the consultation: Conversation analytic study. *British Medical Journal,* 325, 1148-1151.

Norcross, J.C. (Ed.) (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*: Oxford University Press.

Olfson, M., Marcus, S.C., Wilk, J., & West, J.C. (2006). Awareness of illness and nonadherence to antipsychotic medications among persons with schizophrenia. *Psychiatric Services,* 57, 205-211.

Orbuch, T.L. (1997). People's accounts count: The sociology of accounts. *Annual Review of Sociology,* 23, 445-478.

Parry, R. (2009). Practitioners' accounts for treatment actions and recommendations in pshysiotherapy: when do they occur, how are they structured, what do they do? *Sociology of Health and Illness,* 31, 835-853.

Parry, R., Land, V., & Seymour, J. (2014). How to communicate with patients about future illness progression and end of life: A systematic review. *BMJ Supportive & Palliative Care,* 00, 1-11.

Peräkylä, A. (1995). *AIDS conselling: Institutional interaction and clinical practice*. Cambridge: Cambridge University Press.

Peräkylä, A. (1998). Authority and accountability: The delivery of diagnosis in primary health care. *Social Psychology Quarterly,* 61, 301-320.

Pescosolido, B.A., Gardner, C.B., & Lubell, K.M. (1998). How people get into mental health services: stories of choice, coercion and "muddling through" from "first-timers". *Social Science & Medicine,* 46, 275-286.

Pilnick, A., & Dingwall, R. (2011). On the remarkable persistence of asymmetry in doctor/patient interaction: A critical review. *Social Science & Medicine,* 72, 1374-1382.

President's New Freedom Commission on Mental Health. (2003). Transforming mental health care in America. Rockville, MD: SMA-03-3832.

Priebe, S., Dimic, S., Wildgrube, C., Jankovic, J., Cushing, A., & McCabe, R. (2011). Good communication in psychiatry - a conceptual review. *Eauropean Psychiatry,* 26, 403-407.

Quirk, A., Chaplin, R., Lelliott, P., & Seale, C. (2012). How pressure is applied in shared decisions about antipsychotic medication: A conversation analytic study of psychiatric outpatient consultations. *Sociology of Health and Illness,* 34, 95-113.

Roberts, F. (1999). *Talking about treatment: Recommendations for breast cancer adjuvant therapy*. New York: Oxford University Press.

Robinson, J.D. (2004). The sequential organization of "explicit" apologies in naturally occurring English. *Research on Language and Social Interaction,* 37, 291-330.

Robinson, J.D., & Bolden, G.B. (2010). Preference organization of sequence-initiating actions: The case of explicit account solicitations. *Discourse Studies,* 12, 501-533.

Sacks, H. (1972a). An initial investigation of the usability of conversational materials for doing sociology. In D.N. Sudnow (Ed.), *Studies in Social Interaction* pp. 31-74). New York: Free Press.

Sacks, H. (1972b). On the analyzability of stories by children. In J.J. Gumperz, & D. Hymes (Eds.), *Directions in sociolinguistics: The ethnography of communication* pp. 329-345). New York: Holt, Rinehart & Winston.

Salyers, M.P., Matthias, M.S., Fukui, S., Holter, M.C., Collins, L., Rose, N., et al. (2012). A coding system to measure elements of shared decision making during psychiatric visits. *Psychiatric Services, 63,* 779-784.

Say, R., Murtagh, M., & Thomson, R. (2006). Patients' preference for involvement in medical decision making: a narrative review. *Patient Education and Counseling, 60,* 102-114.

Schegloff, E.A. (2007). *Sequence organization in interaction: A primer in conversation analysis.* Cambridge: Cambridge University Press.

Scott, M.B., & Lyman, S.M. (1968). Accounts. *American Sociological Review, 33,* 46-62.

Seale, C., Chaplin, R., Lelliott, P., & Quirk, A. (2006). Sharing decisions in consultations involving anti-psychotic medication: A qualitative study of psychiatrists' experiences. *Social Science & Medicine, 62,* 2861-2873.

Shotter, J. (1984). *Social accountability and selfhood.* Oxford: Blackwell.

Sidnell, J., & Stivers, T. (Eds.) (2013). *The handbook of Conversation Analysis.* Oxford: Blackwell.

Starr, P. (1982). *The social transformation of American medicine*: Basic Books.

Stein, L.I., & Santos, A.B. (1998). *Assertive community treatment of persons with severe mental illness*: WW Norton & Co.

Stivers, T. (2005a). Non-antibiotic treatment recommendations: Delivery formats and implications for patient resistance. *Social Science & Medicine, 60,* 949-964.

Stivers, T. (2005b). Parent resistance to physicians' treatment recommendations: One resource for initiating a negotiation of the treatment decision. *Health Communication,* 18, 41-74.

Stivers, T. (2006). Treatment decisions: negotiations between doctors and parents in acute care encounters. In J. Heritage, & D.W. Maynard (Eds.), *Communication in medical care: Interaction between primary care physicians and patients* pp. 279-312). Cambridge, England: Cambridge University Press.

Stivers, T. (2007). *Prescribing under pressure: Parent-physician conversations and antibiotics.* New York: Oxford University Press.

Toerien, M., Shaw, R., Duncan, R., & Reuber, M. (2011). Offering patients choices: A pilot study of interactions in the seizure clinic. *Epilepsy & Behavior,* 20, 312-320.

Toerien, M., Shaw, R., & Reuber, M. (2013). Initiating decision-making in neurology consultations: 'recommending' versus 'option-listing' and the implications for medical authority. *Sociology of Health and Illness,* 35, 878-890.

Turkington, D., Kingdon, D., & Weiden, P.J. (2006). Cognitive behavior therapy for schizophrenia. *American Journal of Psychiatry,* 163, 365-373.

Woltmann, E.M., & Whitley, R. (2010). Shared decision making in public mental health care: Perspectives from consumers living with severe mental illness. *Psychiatric rehabilitation journal,* 34, 29.